State of Hawaii
Department of Health

Public Health Nursing Branch

CONSENT FOR RELEASE OF INFORMATION

TO: _____
(Name of Individual or Organization Giving Information)

ADDRESS: _____

I, _____ THE UNDERSIGNED, REQUEST AND AUTHORIZE THE
(Parent/Legal Guardian/Patient, if 18 yrs. old)

RELEASE OF THE FOLLOWING INFORMATION, Pertinent medical information about the child's medical condition, precautions needed, and special management plans. Please document this information by completing the Emergency Information Form (EIF).

RELATIVE TO: _____ B.D. _____
(Name of Patient)

ADDRESS: _____

TO: Department of Health; Department of Education; State Emergency Medical Services System; Emergency Medical Services Personnel (911) Team; Emergency Department/Facility
(Name of Individual or Organization Receiving Information)

ADDRESS: _____

This information will be used for the following purpose(s) only:
Information documented on the Emergency Information Form (EIF) will be used in an emergency situation at school/school activities for the provision of emergency care services.

Should the medical record contain any information pertaining to alcohol and/or drug abuse, psychiatric evaluation, treatments and results, HIV testing and results, infectious diseases including Acquired Immune Deficiency Syndrome (AIDS), I, by initialing the following: CONSENT _____ DO NOT CONSENT _____ to release of this information to the requesting party. I understand that redisclosure of this information by the requesting party is strictly prohibited.

This consent may be withdrawn at any time upon written request of the parent, legal guardian or patient (if 18 years and over) or consent will be valid for the purposes stated above and for a period not to exceed one (1) year.

_____ _____
(Signature of Parent, Legal Guardian or Patient, if 18 yrs old) (Date)

_____ _____
(Signature of Agency Representative) (Date)

PHN 28 (rev. 6/01)

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians*

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name: Birth date: Nickname:

Home Address: Home/Work Phone:

Parent/Guardian: Emergency Contact Names & Relationship:

Signature/Consent*:

Primary Language: Phone Number(s):

Physicians:

Primary care physician: Emergency Phone:

Fax:

Current Specialty physician: Emergency Phone:
Specialty:

Fax:

Current Specialty physician: Emergency Phone:
Specialty:

Fax:

Anticipated Primary ED: Pharmacy:

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

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Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	**and why:**
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**